

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10299

10294

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown				c. LENGTH OF STAY IN 1b 2 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent & Queen Anne Hospital				d. STREET ADDRESS Quaker Neck RFD			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last William Daniel Barrett				4. DATE OF DEATH Month Day Year Sept. 18, 1961			
5. SEX male		6. COLOR OR RACE colored		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 2/4/1891	
9. AGE (In years lost birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Farm and various		11. BIRTHPLACE (State or foreign country) Kent Co. Md.	
13. FATHER'S NAME Daniel Barrett (218)				14. MOTHER'S MAIDEN NAME Susie Graves			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 218-30-2222		17. INFORMANT Address RFD Rosa Miller Chestertown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 293X IMMEDIATE CAUSE (a) Anemia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Sept. 16 19 61 to Sept. 18 19 61 that (I) (we) last saw the deceased alive on Sept. 17 19 61 , and that death occurred at M , from the causes and on the date stated above.							
22a. SIGNATURE <i>E. Kester</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 9/18/61	
22c. PHYSICIAN'S NAME (Type) Eugene Kester				22d. ADDRESS Rock Hall, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 9/21/61		23c. NAME OF CEMETERY OR CREMATORY Pomona Cemetery near Chestertown, Md.		23d. LOCATION (City, town, or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Benjamin Oday</i>				ADDRESS Chestertown, Md.		25a. REC'D BY REGISTRAR DATE SEP 22 '61	
				25b. REGISTRAR'S SIGNATURE <i>Arthur L. Fries</i>			

10293

RECEIVED

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10300

CERTIFICATE OF DEATH

Reg. Dist. No. 10295

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Chestertown c. LENGTH OF STAY IN lb short d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Great Oak Yacht Club		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Penna b. COUNTY 75X-3 c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Haverford d. STREET ADDRESS Taylor Lane & Harvest Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Ralph B. Bencker First Middle Last 4. DATE OF DEATH Sept. 3, 1961 Month Day Year		5. SEX male 6. COLOR OR RACE white 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH Dec. 24, 1882 9. AGE (In years last birthday) 78 10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Architect 10b. KIND OF BUSINESS OR INDUSTRY Building 11. BIRTHPLACE (State or foreign country) Penna. 12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Don't know 14. MOTHER'S MAIDEN NAME Mary Bowden	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service) 16. SOCIAL SECURITY NO. yes INFORMANT Mrs. Ralph Bencker (wife) Address Above			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 10 minutes year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Sept 3, 1961 , to Sept 3, 1961 , that I last saw the deceased alive on 19 , and that death occurred at 5:55 AM , from the causes and on the date stated above. ACTUAL SIGNATURE Thomas J. Solon M.D. Chestertown, Md. DATE SIGNED 9/3/61 PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF Sept. 7, 1961 22c. NAME OF CEMETERY OR CREMATORY Laurel Hill Cem. 22d. LOCATION (City, town, or county) (State) Philadelphia, Penna.			
23. FUNERAL DIRECTOR'S SIGNATURE Willis Wells ADDRESS Chestertown, Md. 24a. REC'D BY REGISTRAR SEP 6 '61 24b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

MEDICAL CERTIFICATION

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CENTRAL BANK OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10301

10296

1. PLACE OF DEATH a. COUNTY <u>Kent</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; last place of residence prior to admission) a. STATE <u>md</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Chestertown</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Centreville</u>	
c. LENGTH OF STAY IN TB <u>6 days</u>		d. STREET ADDRESS <u>17X-2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Kent & Queen Anne's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Wendell</u>		4. DATE OF DEATH <u>September 9, 1961</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>N</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 9, 1961</u>	
9. AGE (in years last birthday) <u>6</u> yrs.		IF UNDER 1 YEAR Months <u>6</u> Days <u>6</u> Hours <u>6</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Kent Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Wendell Bordley</u>		14. MOTHER'S MAIDEN NAME <u>Adelena Brown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>none</u>		16. SOCIAL SECURITY NO. <u>no</u>	
17. INFORMANT <u>Mother</u>		Address <u>Centreville Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>774X Prematurity - No digestive function</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>function</u> DUE TO (c) <u>function</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 3</u> , 19 <u>61</u> , to <u>Sept 9</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 3</u> , 19 <u>61</u> , and that death occurred at <u>2:11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>C. R. Bayton</u>		22b. DATE SIGNED <u>Sept 9, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>C. R. Bayton</u>		22d. ADDRESS <u>Centreville Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>9/10/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Burrisville Cem.</u>		23d. LOCATION (City, town or county) (State) <u>nr. Centreville, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Benneth Wiley</u>		ADDRESS <u>Chestertown, Md.</u>	
25a. REC'D BY REGISTRAR <u>SEP 13 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Thomas</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10302

CERTIFICATE OF DEATH

10297

1. PLACE OF DEATH a. COUNTY <u>Kent</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> c. LENGTH OF STAY IN <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>1 Hawthorne Rd.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Kent</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rock Hall</u> d. STREET ADDRESS <u>1 Hawthorne Rd.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Ina Buck Downey</u>		4. DATE OF DEATH <u>Sept 22 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 12, 1894</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House wife</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Rock Hall Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Lemuel Buck</u>	
14. MOTHER'S MAIDEN NAME <u>Sarah Watson</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO. <u>216-10-2014</u>		17. INFORMANT <u>James Maurice Downey</u> Address <u>Rock Hall Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u> DUE TO (b) <u>Cardio Vascular</u> DUE TO (c) <u>Emphysema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 1</u> to <u>Sept 21</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Sept 21</u> , 19 <u>61</u> , and that death occurred at <u>2:45</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Norbert C. Nitsch</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>NORBERT-C-NITSCH</u>		22d. ADDRESS <u>Rock Hall MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>9/24/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Wesley Chapel Am.</u>	23d. LOCATION (City, town or county) (State) <u>Rock Hall Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Marvin L. Williams</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Hanes</u>	
ADDRESS <u>Chesapeake Md.</u>		25b. REGISTRAR'S SIGNATURE <u>SEP 25 '61</u>	

5830

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10303

CERTIFICATE OF DEATH

Reg. Dist. No. 10298

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN life adult life d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Kent St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 Chestertown d. STREET ADDRESS 1 Kent St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Otis Houston Flowers		4. DATE OF DEATH Month Sept. Day 6 Year 1961	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 11, 1911
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk at A.P. Food Stores		10b. KIND OF BUSINESS OR INDUSTRY Dorchester Co. Maryland	12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME Walter D. Flowers		14. MOTHER'S MAIDEN NAME Julia Adams	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-14-4000	INFORMANT Lillie Mae Flowers Address Chestertown, Md.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary insufficiency 241X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Chronic obstructive pulmonary emphysema DUE TO (c) Asthma			INTERVAL BETWEEN ONSET AND DEATH 2 hours 10 years 30 years
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month _____ Day _____ Year 19 Hour a. m. _____ p. m. _____	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from January 19 55 , to September 6 , 19 61 that I last saw the deceased alive on September 6 , 19 61 , and that death occurred at 9 p. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 9/7/61			
ACTUAL SIGNATURE A. C. Dick M.D.		PHYSICIAN'S NAME (Type) A. C. Dick Chestertown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 9/9/61	22c. NAME OF CEMETERY OR CREMATORY Chestertown, Md.	22d. LOCATION (City, town, or county) (State) Chestertown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells ADDRESS Chestertown, Md.		24a. REC'D BY REGISTRAR SEP 11 '61 DATE	24b. REGISTRAR'S SIGNATURE Arthur S. Hines

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10304

CERTIFICATE OF DEATH

10299

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY in lb 15 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Agnes Middle Quail Last Francis		4. DATE OF DEATH Month 9 Day 21 Year 19 61	
5. SEX Female 6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 7/10/91 9. AGE (In years last birthday) 70 yrs. IF UNDER 1 YEAR: Months 7 Days 10 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.A.		11. BIRTHPLACE (County & State, or foreign country) Maryland	
13. FATHER'S NAME John Lewis		14. MOTHER'S MAIDEN NAME Agnes Quail	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 1	
17. INFORMANT Mrs. June Stenger, Rock Hall, Md. (daughter)		Address Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Choleemia 581.0 DUE TO Carbonic acid Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Carbonic acid DUE TO (c) Carbonic acid		INTERVAL BETWEEN ONSET AND DEATH 7 days 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Rheumatoid arthritis		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 9-1 to 9-21 , 19 61 , that (I) (we) last saw the deceased alive on 9-21 , 19 61 , and that death occurred at 149 PM , from the causes and on the date stated above.			
22a. SIGNATURE A.C. Dick		22b. DATE SIGNED 9-22-61	
22c. PHYSICIAN'S NAME (Type) A.C. Dick		22d. ADDRESS Chestertown	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 9/24/61	
23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		23d. LOCATION (City, town or county) (State) Rock Hall Ind.	
24. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		25a. REC'D BY REGISTRAR SEP 27 '61	
ADDRESS Chesapeake Hall Md.		25b. REGISTRAR'S SIGNATURE Arthur L. House	

10389

Kent

Mayland

Rock Hill

15 days

10384

Kent

Washington

North & South Wales, Rock Hill

Brussels

Wall

James

Parish White

WYOMING

TO

Harvard

Honorable

John Lewis

Green Wall

Mrs. Anne Strong, Rock Hill, W. (daughter)

No

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
10305 CERTIFICATE OF DEATH 10300											
1. PLACE OF DEATH a. COUNTY KENT b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CHESTERTOWN. c. LENGTH OF STAY in 1b life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) KENT & QUEEN ANNE'S				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MD. b. COUNTY KENT. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 37 CHESTERTOWN. d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) ANNALISA MARIA JOHNSON				4. DATE OF DEATH SEPT. 20 1961							
5. SEX FE.		6. COLOR OR RACE N.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-18-61		9. AGE (In years last birthday) yrs. 3		IF UNDER 1 YEAR Months 3 Days 3	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none				10b. KIND OF BUSINESS OR INDUSTRY none				11. BIRTHPLACE (County & State, or foreign country) Kent Co. Maryland			
12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME Allen JOHNSON				14. MOTHER'S MAIDEN NAME RUBY MOORE							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none				16. SOCIAL SECURITY NO. none				17. INFORMANT Hospital Records			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable subdural hemorrhage 760.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Some what traumatic labor & delivery DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 36 hours										INTERVAL BETWEEN ONSET AND DEATH 36 hours	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 9/18/61 , to 9/20/61 , that (I) (we) last saw the deceased alive on 9/20/61 , and that death occurred at 5:20 M, from the causes and on the date stated above.											
22a. SIGNATURE Robert W. Farr				22b. DATE SIGNED 9/20/61							
22c. PHYSICIAN'S NAME (Type) ROBERT W. FARR				22d. ADDRESS Chestertown, Md							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 9/21/61		23c. NAME OF CEMETERY OR CREMATORY Pomona Cemetery		23d. LOCATION (City, town or county) (State) Nr. Chestertown, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth W. Daley				ADDRESS Chestertown, Md.				25a. REC'D BY REGISTRAR SEP 22 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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Journal

Land Co. Maryland

none

Hospital records

none

Some of the following are
probably included in the
above

12 8/20

11/10/22

12/21

JOSEPH W. FARR

12/21/22

London Cemetery

12/21/22

12/21/22

Westchester County, N.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10306

10301

1. PLACE OF DEATH e. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown R. D. 3 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Quaker Neck		2. USUAL RESIDENCE (Where deceased lived, if institution; if abroad, give address) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown R. D. 3 d. STREET ADDRESS Quaker Neck	
3. NAME OF DECEASED (Type or print) William Greensborough Johnson		4. DATE OF DEATH Month September Day 11 Year 1961	
5. SEX Male	6. COLOR OR RACE Col.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 2, 1918
9. AGE (In years last birthday) 43 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer	
11. BIRTHPLACE (County & State, or foreign country) Queen Anne Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David Thos. Johnson		14. MOTHER'S MAIDEN NAME Bessie Goldsborough	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 514-18-4101	
17. INFORMANT Mrs. Mary G. Johnson		Address Chestertown R.D. 3 Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (e), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH 1 month ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Sept 7, 1961 , to Sept 11, 1961 , that (I) (we) last saw the deceased alive on Sept 11, 1961 , and that death occurred at 9 P.M. from the causes and on the date stated above.			
22a. SIGNATURE Thomas J. Solon		22b. DATE SIGNED 9/12/61	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 14/61	
23c. NAME OF CEMETERY OR CREMATORY Uniontown Cemetery		23d. LOCATION (City, town or county) (State) Near Church Hill, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams		25. REGISTRAR'S SIGNATURE SEP 15 61	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by filling in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

10307

10302

1. PLACE OF DEATH a. COUNTY Kent MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Kent			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Chestertown				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RFD - Georgetown Section				d. STREET ADDRESS RFD # 2			
3. NAME OF DECEASED (Type or print) Ida Jones				4. DATE OF DEATH Month Sept. Day 23 Year 1961			
5. SEX female		6. COLOR OR RACE colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 26, 1872	
9. AGE (In years last birthday) 89		10. IF UNDER 1 YEAR Months 0 Days 0		11. IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Kent Co. Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Samuel Cotton				14. MOTHER'S MAIDEN NAME Sarah Ward (Cotton)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Address Ardena Groce RFD Chestertown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 794X DUE TO Conditions, if any, which gave rise to immediate cause (b) 794X (a), stating the underlying cause last, DUE TO (c) 794X							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 1961 to Sept. 23, 1961 , that (I) (we) last saw the deceased alive on Sept. 22, 1961 , and that death occurred at 4 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Eugene Kester				22b. DATE 9/24/61			
22c. PHYSICIAN'S NAME (Type) Eugene Kester				22d. ADDRESS Rock Hall, Maryland			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Sept. 27, 1961		23c. NAME OF CEMETERY OR CREMATORY Georgetown Cem.		23d. LOCATION (City, town or county) (State) near Chestertown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Kenneth Woolley				25a. REC'D BY REGISTRAR DATE SEP 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

10308

CERTIFICATE OF DEATH

10303

Item 8 Film G297 10/6/61 ink

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Md. b. COUNTY Kent	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millington		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Millington	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Alphonso Middle Last Keys		4. DATE OF DEATH Month September Day 29 Year 1961	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April, 1, 1880
9. AGE (In years last birthday) 71 yrs.		10. AGE (In years last birthday) 71 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Labor		10b. KIND OF BUSINESS OR INDUSTRY Farming.	
11. BIRTHPLACE (County & State, or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME No Record		14. MOTHER'S MAIDEN NAME No Record	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 169-12-2095	
17. INFORMANT Estella Ricketts,		Address Millington, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobar Pneumonia 490X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 24, 61 to Sept 29, 61 , that (I) (we) last saw the deceased alive on Sept 24, 61 , and that death occurred at 4:30 PM , from the causes and on the date stated above.			
22a. SIGNATURE H. H. Hamilton		22b. DATE Sept 30, 61	
22c. PHYSICIAN'S NAME (Type) H. H. HAMILTON		22d. ADDRESS Millington, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Oct. 2, 1961	
23c. NAME OF CEMETERY OR CREMATORY Millington Col. Cemetery		23d. LOCATION (City, town or county) (State) Millington, Kent Co; Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Edward Hollows,		25a. REC'D BY REGISTRAR OCT 3 '61	
ADDRESS Millington, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hanna	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

10303

10304

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Chestertown c. LENGTH OF STAY IN lb 12 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Kent & Queen Anne's Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Still Pond d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Margaret Sarah Nicholson			4. DATE OF DEATH Month 9 Day 18 Year 19 61				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/14/01		9. AGE (In years last birthday) 60 yrs. IF UNDER 1 YEAR: Months 60 Days 0 Hours 0 Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY Delaware		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Hander Lesage			14. MOTHER'S MAIDEN NAME Jenny Lee				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-16-3112		17. INFORMANT Oliver C. Nicholson, Still Pond, Maryland Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 80%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock, and lower nephron nephrosis Probable coronary thrombosis (b) Chill, cause unknown, following ligation of left ureter (c) 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.</p> </div> <div style="width: 15%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> <p>48</p> <p>48</p> </div> </div> <p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from 9/86 to 9/18 , 19 61 that (I) (we) last saw the deceased alive on 9/18/61 , 19 61 , and that death occurred 12:25 AM the causes and on the date stated above.							
22a. SIGNATURE Robert W. Farr			22b. DATE SIGNED 9/18/61		22c. PHYSICIAN'S NAME (Type) Robert W. Farr		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 9/20/61		23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemty		
23d. LOCATION (City, town or county) Chestertown, Md.			23e. LOCATION (City, town or county) Sudlersville, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Victor N. Kennedy			24a. REC'D BY REGISTRAR SEP 19 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Hines		

(M)

10302

10304

Hand

Hand

Chesapeake

12 days

Still found

Hand & upper arm's blood

Marxist

James

Johnson

Female

White

W/M/O

Housewife

Belmont

U.S.

Handy Lane

Jenny Lee

Oliver C. Johnson, Still found, 10302

no

Cardiac shock, and lower neck on neck
Probable coronary thrombosis
Chill, cause unknown, following litigation
of left breast

(I)

x

8/12/61

11:25 AM

ok

9/18

81

x

9/19/61

Robert W. Farr

Chesapeake, Md.

Hand

Hand

Hand

Still found

Hand

Hand

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the delay by filing this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for the funeral director. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

10305

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence of family) b. STATE Penna c. COUNTY Berks	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) near Rock Hall		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple 75X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) D Summer home		d. STREET ADDRESS 4729 Kutztown Rd. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Gilbert M. Sawyer		4. DATE OF DEATH Sept. 18, 1961 19	
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 24, 1892
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10b. KIND OF BUSINESS OR INDUSTRY Mushroom Broker	
11. BIRTHPLACE (State or foreign country) New Jersey		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George Sawyer		14. MOTHER'S MAIDEN NAME Sabra Plum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) don't know		16. SOCIAL SECURITY NO. 180-01-2280	
17. INFORMANT Mrs. Gilbert Sawyer, Jr. Address Temple, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Probable Coronary Thrombosis DUE TO Coronary Arteriosclerosis Conditions, if any, which gave rise to immediate cause (b) Deceased was known to have a bad heart. He took nitroglycerin often. was found lying on ground (c) By a neighbor Mr. R. S. Kent PART II. OTHER SIGNIFICANT CONDITIONS DESCRIBED BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH short	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) no injury	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE Robert W. Farr		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) Robert W. Farr		DATE SIGNED 9/18/61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9/22/61	
22c. NAME OF CEMETERY OR CREMATORY Laureldale Cem.		22d. LOCATION (City, town, or county) (State) Berks County, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE J. Willis Wells		ADDRESS Chestertown, Md.	
24a. REC'D BY REGISTRAR DATE SEP 22 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Thoma	

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
10310 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. OCCUPATION	
6. PLACE OF BIRTH		7. DATE OF BIRTH		8. DATE OF DEATH		9. TIME OF DEATH		10. PLACE OF DEATH	
11. CAUSE OF DEATH		12. MANNER OF DEATH		13. SIGNATURE OF EXAMINER		14. SIGNATURE OF WITNESS		15. SIGNATURE OF CORONER	
16. SIGNATURE OF DECEASED		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF PHYSICIAN		19. SIGNATURE OF NURSE		20. SIGNATURE OF CHAPLAIN	
21. SIGNATURE OF MINISTER		22. SIGNATURE OF RABBI		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER	
26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER	
36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER	
41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER	
46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER	
51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER	
56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER	
61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER	
66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER	
71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER	
81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER	
86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER	
91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER	
96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
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10311

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

10306

1. PLACE OF DEATH a. COUNTY Kent b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall c. LENGTH OF STAY IN 1b Rock Hall d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Kent c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall d. STREET ADDRESS Rock Hall e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Addie Middle L. Last Thompson		4. DATE OF DEATH Month Sept. Day 13 Year 1961	
5. SEX Fem	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 15-1879
9. AGE (In years lost birthday) 81 yrs.		10. IF UNDER 1 YEAR Months 81 Days 13 Hours 13 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Thomas Parsons		14. MOTHER'S MAIDEN NAME Eliza Ivens	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Jesse Downey--Rock Hall, Maryland	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Terminal bronchopneumonia 334X DUE TO Enforced bed care Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. recurrent small strokes DUE TO recurrent small strokes PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) recurrent small strokes		INTERVAL BETWEEN ONSET AND DEATH 10 days several years several years	
18a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		18b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
19a. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		19b. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
19c. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		19d. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1959 to 9-13 , 1961, that I last saw the deceased alive on 9/13 , 1961, and that death occurred at 2 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Robert W. Farr		ADDRESS (Street, city or town, state) Chestertown, Md.	
PHYSICIAN'S NAME (Type) ROBERT W. FARR		DATE SIGNED 9-14-61	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Sept. 15	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Rock Hall, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Md.	
24a. REC'D BY REGISTRAR SEP 19 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Thomas	

10311

CENTRAL & SOUTHERN

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Kent MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rock Hall		c. LENGTH OF STAY IN lb lifetime	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION (Gratitude Section)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Blanche Williams		4. DATE OF DEATH Month Day Year Sept. 10, 1961 19	
5. SEX female	6. COLOR OR RACE colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 26, 1893
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? Usa	
13. FATHER'S NAME Daniel Butler		14. MOTHER'S MAIDEN NAME Frances Thompson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Wm. Lee - Rock Hall, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Edema</i> 444X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (b) <i>Hypertension</i> DUE TO (c) <i>Arterio Sclerosis</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 1</i> 19 <i>61</i> , to <i>Sept 10</i> 19 <i>61</i> , that (I) (we) last saw the deceased alive on <i>Sept 9</i> 19 <i>61</i> , and that death occurred at <i>2 A</i> M, from the causes and on the date stated above.			
22a. SIGNATURE <i>Norbert C. Nitsch</i>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Norbert C. Nitsch		22d. ADDRESS Rock Hall, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 9 9/12/61	23c. NAME OF CEMETERY OR CREMATORY Sharptown Cemetery	23d. LOCATION (City, town, or county) (State) near - Rock Hall, Md.
24. FUNERAL DIRECTOR'S SIGNATURE <i>Benneth Waller</i>		25a. REC'D BY REGISTRAR DATE SEP 13 '61	
ADDRESS Chestertown, Md.		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>	

